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Current Trends

Family and Other Intimate Assaults – Atlanta, 1984

Although violence between spouses is well documented as a serious problem (*1–4*), public health and safety agencies need improved characterization of violence in intimate relationships to develop prevention strategies. This report summarizes a recent study in Atlanta that examined the incidence of family and other intimate assaults (FIAs) (i.e., assaults in which victim and perpetrator[s] were emotionally intimate at the time of or before the incident). FIAs occurred in a range of emotionally intimate relationships (e.g., siblings, parent-child, other relatives [including in-laws], married and unmarried partnerships, and terminated partnerships) (*5*).

Incident reports for 1984 from the Bureau of Police Services for the City of Atlanta* were reviewed to identify fatal and nonfatal FIAs. To be included, an incident report must have been classified either as a homicide or a nonfatal incident, with the latter involving one or more of the following circumstances: physical contact between persons, use of a weapon, threat with a weapon, and/or explicit verbal threat of bodily harm. In addition, Atlanta must have been the location of both the incident and the victim's residence.

One hundred seventy-seven FIAs were selected, including 27 fatal and 150 nonfatal incidents.† Victims were predominantly female (52% of fatal FIAs and 73% of nonfatal FIAs). Perpetrators were predominantly male (74% fatal, 80% nonfatal). The estimated nonfatal FIA victimization rate for Atlanta was 837 per 100,000 population, compared with a fatal FIA victimization rate of seven per 100,000 population (Table 1). Women were 2.4 times more likely than men to be victims of nonfatal FIAs. For fatal incidents, the rate for women equaled the rate for men. Both the fatal and the estimated nonfatal FIA rates for blacks and other races were three times the respective rates for whites.

Of the 177 FIAs, 165 (23 fatal, 142 nonfatal) involved one perpetrator and one victim. Of these, more than half of both fatal and nonfatal FIAs occurred between

*For this report, Atlanta is defined as that portion of the City of Atlanta located within Fulton County. Approximately 95% of the city's land mass and 91% (in 1984, 389,700 persons) of its population are within Fulton County.

†All 1984 homicides (n = 27) meeting the inclusion criteria were selected. A stratified random sample (n = 150) of nonfatal incidents was selected from incident reports stratified across seven crime categories (i.e., rape, robbery, assault, disorderly conduct, family and children offense, sex offense, and other).

Assaults — Continued

spousal or nonspousal partners in relationships ongoing when the incident occurred (Figure 1). More than one fifth of both fatal and nonfatal incidents involved terminated or estranged relationships. When combined, current and former partnerships accounted for 74% of fatal FIAs and 77% of nonfatal FIAs.

Police incident reports indicated that most of the 165 victims suffered some type of physical injury. In fatal incidents, twice as many victims suffered gunshot wounds (61%) as cuts or stab wounds (30%). In nonfatal incidents, 4% of victims suffered gunshot wounds; 32%, cuts or stab wounds; and 30%, some other type of injury. For the other one third of victims in nonfatal incidents, police incident reports indicated no physical injuries.

At least 26% of the fatal and 34% of the nonfatal incident perpetrators and 30% and 37% of victims, respectively, had one or more prior police contacts involving FIA. Approximately one fourth of all participants had prior police contact for FIA involving the same coparticipant as in the 1984 incident.

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Editorial Note: Injury is the leading cause of years of potential life lost in the United States and accounts for an estimated $180 billion dollars in direct and indirect costs each year (*6*). Violence between persons who are related, share a household, or are otherwise intimate with each other is a widespread public health problem and a substantial contributor to the public health impact of injuries (*7,8*). In particular,

TABLE 1. Rates of fatal and nonfatal family and other intimate assaults (FIAs), by sex and race of victim — Atlanta, 1984

Category	Annual rate*	95% CI†	Rate ratio
Fatal		NA§	
Sex			
Male	7		1.0¶
Female	7		1.0
Race			
White	3		1.0**
Black and other	9		3.0
Total	**7**		
Nonfatal (estimated)			
Sex			
Male	479	357–641	1.0¶
Female	1154	968–1376	2.4
Race			
White	359	228–565	1.0**
Black and other	1072	918–1253	3.0
Total	**837**	**724–967**	

*Per 100,000 population.
†Confidence interval.
§Rates were derived from total fatal FIAs in 1984.
¶Referent group for ratio of sex group rates.
**Referent group for ratio of race group rates.

Assaults – Continued

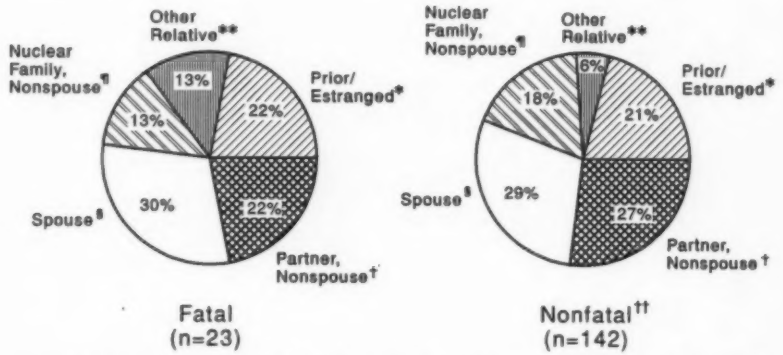
intimate violence is a leading cause of injuries to women; in one study, battering was responsible for more injuries to women than were motor vehicle crashes, rape, and mugging combined (*9*). Overall, however, additional data are needed to further characterize intimate violence.

This study of FIAs in Atlanta was initiated to better define the nature and pattern of these assaults, assess the use of data from a wide range of disciplines and service agencies, examine the prevention potential of interagency cooperation, and ultimately suggest new ways to prevent this important source of injuries.

In 1984, for each reported fatal FIA, 120 police incident reports involved nonfatal FIAs. Because FIAs are substantially underreported and/or improperly categorized, fatal and nonfatal victimization rates based on police reports provide an incomplete assessment of FIAs (*2,4*). Additionally, because comparable rates do not exist for other urban areas, the magnitude of the problem in Atlanta cannot be compared with that in similar jurisdictions. Collection of data on the characteristics of FIAs in different locations would permit comparisons of rates and assist efforts to determine the effectiveness of different prevention strategies.

At least one fifth of the incidents in this study involved nonspousal partnerships. An additional fifth involved partners who were estranged or whose relationships had previously ended; this finding indicates that violence occurs even after termination of an intimate relationship. Strategies for protecting women who have terminated abusive relationships but remain at risk for injury or death should be incorporated into existing efforts by police, health, and social service agencies to prevent FIAs.

FIGURE 1. Proportion of family and other intimate assaults, by relationship – Atlanta, 1984



*Includes ex-boyfriend/ex-girlfriend relationships, separated and divorced spouses, former cohabiting partners (heterosexual or homosexual), and estranged noncohabiting homosexual partners.

†Includes boyfriend/girlfriend relationships, cohabiting partners (heterosexual or homosexual), and noncohabiting homosexual partners.

§Includes common-law marriages.

¶Includes sibling and parent-child relationships.

**Includes in-laws.

††Estimated percentages are based on a sample (n = 142) of total incidents.

Assaults — Continued

Although most FIA victims suffer injuries and often seek medical attention for their injuries, medical records frequently do not provide information (e.g., the determination of whether an injury was intentional and the relationship of victim and perpetrator) necessary to estimate FIA incidence. In some states, laws require hospitals to report domestic violence (*10*); nonetheless, episodes of domestic violence involving adult female patients may be identified correctly by medical personnel as infrequently as 5% of the time (*11*)—possibly because most health-care providers are not trained to recognize interpersonal violence (*12*) and may not be aware of the health implications of repetitive violence. Physician training should promote not only recognition, treatment, and referral of victims but also primary prevention.

Since FIAs are often repeated, information about prior incidents can contribute to preventive efforts by identifying persons at high risk for being victims or perpetrators. Investigators have recently found that use of standardized protocols to screen trauma patients in a hospital emergency department substantially increased the ability of health-care providers to identify battered women (*13*). Once identified, victims can be referred to service providers (e.g., counselors and battered women's shelters). In addition to arrest, perpetrators can also be referred to counseling programs (e.g., programs for men who batter). Improved medical record data can also potentially complement and clarify estimates of FIA incidence derived from police incident reports by providing a more complete description of the health consequences of family and intimate violence. The productive interactions of public health, social service, and criminal justice agencies is necessary for the ultimate success of efforts to prevent interpersonal violence.

References

1. Mercy JA, Saltzman LE. Fatal violence among spouses in the United States, 1976–85. Am J Public Health 1989;79:595–9.
2. Schulman MA. A survey of spousal violence against women in Kentucky. Washington, DC: US Department of Justice, 1979.
3. Straus MA, Gelles RJ. Physical violence in American families: risk factors and adaptations to violence in 8,145 families. New Brunswick, New Jersey: Transaction Publishers, 1990.
4. Teske RHC Jr, Parker ML. Spouse abuse in Texas: a study of women's attitudes and experiences. Huntsville, Texas: Survey Research Program, Criminal Justice Center, Sam Houston State University, 1983.
5. Saltzman LE, Mercy JA, Rosenberg ML, et al. Magnitude and patterns of family and intimate assault in Atlanta, Georgia, 1984. Violence and Victims 1990;5:3–17.
6. Rice DP, MacKenzie EJ, Jones AS, et al. The cost of injury in the United States: a report to Congress. San Francisco: University of California, Institute for Health and Aging; Johns Hopkins University, Injury Prevention Center, 1989.
7. Rosenberg ML, Gelles RJ, Holinger PC, et al. Violence: homicide, assault, and suicide. In: Amler RW, Dull HB, eds. Closing the gap: the burden of unnecessary illness. New York: Oxford University Press, 1987:164–78.
8. US Department of Health and Human Services/US Department of Justice. Surgeon General's Workshop on Violence and Public Health: report. Washington DC: US Department of Health and Human Services, Health Resources and Services Administration, 1986; publication no. HRS-D-MC 86-1.
9. Rosenberg ML, Stark E, Zahn MA. Interpersonal violence: homicide and spouse abuse. In: Last JM, ed. Public health and preventive medicine. 12th ed. Norwalk, Connecticut: Appleton-Century-Crofts, 1986:1399–426.
10. Lerman LG, Livingston F. State legislation on domestic violence. Response to Violence in the Family and Sexual Assault 1983;6:1–28.
11. Stark E, Flitcraft A, Zuckerman D, Grey A, Robison J, Frazier W. Wife abuse in the medical setting: an introduction for health personnel. Washington, DC: US Department of Health and

Assaults – Continued

Human Services, Administration for Children, Youth, and Families, Office on Domestic Violence, 1981. (Monograph no. 7).
12. CDC. Education about adult domestic violence in US and Canadian medical schools, 1987–88. MMWR 1989;38:17–9.
13. McLeer SV, Anwar R. A study of battered women presenting in an emergency department. Am J Public Health 1989;79:65–6.

Update: Reducing HIV Transmission in Intravenous-Drug Users Not in Drug Treatment – United States

In 1987, the National Institute on Drug Abuse (NIDA) initiated ongoing demonstration projects to study and change the high-risk behaviors of both intravenous-drug users (IVDUs) who were not enrolled in drug treatment and their sex partners (*1*). The goal of the projects is to eliminate or reduce the likelihood of human immunodeficiency virus (HIV) transmission from these two high-risk groups. As of July 1, 1990, the projects included >30,000 IVDUs and their sex partners in 41 community-based programs. This report describes preliminary data (as of January 1990) based on follow-up interviews of 1584 primarily <40-year-old, black, male IVDUs recruited from 1987 through 1989 in Chicago, Houston, Miami, Philadelphia, and San Francisco (Table 1, page 535).

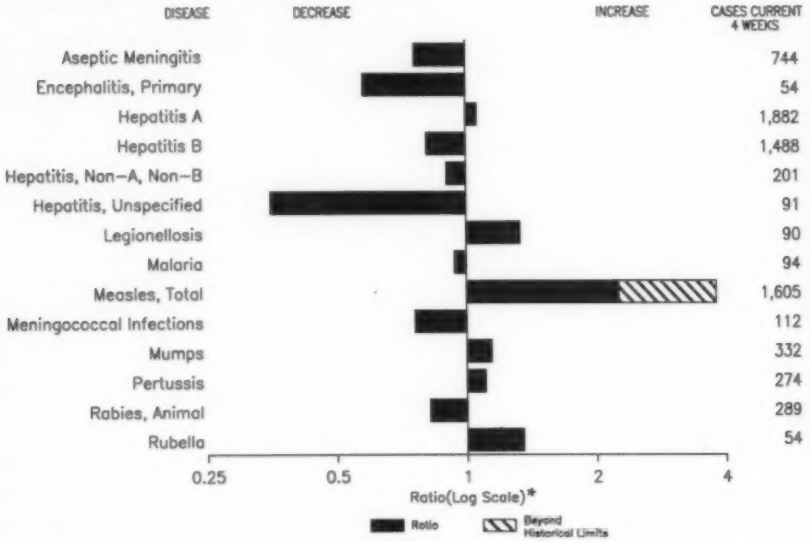
In these projects, IVDUs were recruited through community-based outreach workers who were familiar with the neighborhoods in which the programs operate, were often former drug users, and had access to neighborhoods in which drugs were used. Eligibility criteria for participants included intravenous (IV)-drug use during the 6 months before recruitment and no enrollment in a drug-treatment program during the 30 days before recruitment. Clients were paid for their participation. The return rates for participants from initial to follow-up interviews were >65% in four cities—ranging from 45% (Houston) to 78% (Philadelphia).

The specific interventions to reduce risk behaviors varied by city but included one or more of the following: 1) individual and group counseling, 2) efforts to build peer support for behavior change, and/or 3) demonstration and practice of behaviors that reduce risk. All interventions emphasized termination of IV-drug use. IVDUs were urged to start drug treatment as soon as it became available to them. In all cities, the programs strongly encouraged those who did not stop IV-drug use to 1) stop sharing drug-injection equipment (e.g., needles and syringes, drug-cooking implements, and rinse water); 2) use only sterile needles and syringes from unopened packages; and/or 3) disinfect drug-injection equipment with bleach or other appropriate agents. The interventions related to sexual activity advocated celibacy and, for persons who were sexually active, safer sexual practices, including use of condoms and reduction of the number of sex partners.

Fourteen percent to 35% of IVDUs participating in the first follow-up interview had entered a drug-treatment program during the approximately 6 months after enrollment (Table 1). Forty-nine percent to 75% of IVDUs reported stopping or decreasing their frequency of drug injection during the approximately 6 months between the initial intervention and follow-up interview (Table 1)—including 16%–47% who reported stopping all use of IV drugs.

(Continued on page 535)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending August 4, 1990, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from comparable, previous, and subsequent 4-week periods for past 5 years).

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending August 4, 1990 (31st Week)

	Cum. 1990		Cum. 1990
AIDS	25,109	Plague	1
Anthrax	-	Poliomyelitis, Paralytic*	-
Botulism: Foodborne	4	Psittacosis	73
Infant	34	Rabies, human	1
Other	2	Syphilis: civilian	28,356
Brucellosis	41	military	150
Cholera	2	Syphilis, congenital, age < 1 year	45
Congenital rubella syndrome	2	Tetanus	34
Diphtheria	1	Toxic shock syndrome	199
Encephalitis, post-infectious	60	Trichinosis	16
Gonorrhea: civilian	388,188	Tuberculosis	12,688
military	5,327	Tularemia	63
Leprosy	115	Typhoid fever	232
Leptospirosis	27	Typhus fever, tickborne (RMSF)	300
Measles: imported	826		
indigenous	16,438		

*Three cases of suspected poliomyelitis have been reported in 1990; five of 13 suspected cases in 1989 were confirmed and all were vaccine-associated.

TABLE II. Cases of specified notifiable diseases, United States, weeks ending August 4, 1990, and August 5, 1989 (31st Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionellosis	Leprosy
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1989	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1990
UNITED STATES	25,109	3,640	394	60	388,188	403,934	17,024	11,876	1,253	1,018	648	115
NEW ENGLAND	907	144	14	-	10,874	11,341	353	632	39	44	30	8
Maine	40	6	1	-	121	164	5	24	4	1	3	-
N.H.	40	12	-	-	119	108	5	27	3	2	3	-
Vt.	10	16	2	-	34	40	4	33	3	-	5	-
Mass.	699	43	5	-	4,442	4,397	248	398	19	39	14	7
R.I.	50	46	1	-	690	824	35	29	-	2	5	1
Conn.	268	21	5	-	5,468	5,808	56	121	10	-	-	-
MID. ATLANTIC	7,535	363	33	4	54,230	60,696	2,437	1,676	144	70	194	17
Upstate N.Y.	942	181	28	1	7,743	9,208	644	429	38	20	77	1
N.Y. City	4,293	73	2	1	22,930	23,923	293	463	22	33	35	12
N.J.	1,538	-	1	-	9,417	9,353	245	373	30	-	33	3
Pa.	762	109	2	2	14,140	18,212	1,255	411	54	17	49	1
E.N. CENTRAL	1,812	535	84	11	73,779	72,865	1,329	1,453	93	64	147	1
Ohio	440	127	20	3	23,282	19,391	127	264	31	9	52	-
Ind.	153	101	2	6	6,482	5,129	74	281	5	14	30	-
Ill.	740	86	26	2	22,650	23,592	659	268	26	15	8	1
Mich.	330	195	34	-	16,911	18,608	240	412	23	26	42	-
Wis.	149	26	2	-	4,454	6,145	229	228	8	-	15	-
W.N. CENTRAL	558	158	35	1	20,611	17,942	973	548	87	23	34	-
Minn.	93	12	11	1	2,508	1,923	152	75	21	-	-	-
Iowa	25	20	4	-	1,477	1,588	192	41	7	2	3	-
Mo.	328	82	3	-	12,505	10,738	311	330	36	17	20	-
N. Dak.	2	7	-	-	55	84	10	4	2	1	-	-
S. Dak.	2	5	2	-	131	150	117	5	3	-	-	-
Nebr.	29	13	7	-	970	873	57	23	4	-	6	-
Kans.	79	19	8	-	2,965	2,586	134	70	14	3	5	-
S. ATLANTIC	5,349	801	92	18	111,729	108,712	2,060	2,252	192	160	99	4
Del.	58	25	3	-	1,870	1,802	85	61	6	1	5	-
Md.	555	94	12	1	12,714	12,015	745	320	26	8	35	2
D.C.	445	2	-	-	7,722	7,245	12	28	4	-	-	-
Va.	497	104	34	2	9,756	9,033	166	126	26	118	7	-
W. Va.	38	25	10	-	691	841	12	53	3	2	3	-
N.C.	371	76	23	-	17,488	16,275	457	632	77	-	15	1
S.C.	233	12	1	-	8,856	9,980	27	367	12	8	15	-
Ga.	769	158	4	1	24,786	21,089	216	266	7	7	12	-
Fla.	2,383	305	5	14	27,846	30,432	340	399	31	16	7	1
E.S. CENTRAL	629	360	32	1	31,779	31,621	240	904	86	5	44	-
Ky.	111	84	10	-	3,571	3,074	60	313	30	4	18	-
Tenn.	193	56	16	1	9,954	10,351	112	484	40	-	14	-
Ala.	129	155	6	-	10,124	10,177	67	103	14	-	12	-
Miss.	196	65	-	-	8,130	8,019	1	4	2	1	-	-
W.S. CENTRAL	2,781	390	18	6	38,995	42,092	1,749	1,178	57	167	34	27
Ark.	104	7	1	-	5,218	4,854	299	51	6	12	7	-
La.	434	56	4	-	7,846	8,658	117	187	2	6	11	-
Okla.	147	31	2	5	3,603	3,575	344	86	19	15	12	-
Tex.	2,096	296	11	1	22,328	25,005	989	854	30	134	4	27
MOUNTAIN	674	185	16	-	7,617	8,575	2,735	894	112	79	27	-
Mont.	9	3	-	-	107	117	74	44	4	4	2	-
Idaho	16	-	-	-	80	117	49	55	8	-	3	-
Wyo.	1	1	1	-	94	57	31	9	5	1	-	-
Colo.	218	43	3	-	1,562	1,876	169	95	28	28	3	-
N. Mex.	54	9	-	-	751	832	513	108	8	2	2	
Ariz.	213	92	6	-	3,186	3,231	1,422	318	35	30	9	-
Utah	61	21	2	-	247	264	261	57	15	5	3	-
Nev.	102	16	4	-	1,590	2,081	216	208	9	9	5	-
PACIFIC	4,864	704	70	19	39,574	50,090	5,148	2,339	443	406	39	58
Wash.	381	-	4	1	3,091	3,958	881	369	80	16	9	3
Oreg.	184	-	-	-	1,513	1,773	520	260	31	7	-	-
Calif.	4,194	594	61	17	33,048	43,516	3,564	1,631	320	377	29	47
Alaska	22	54	4	-	621	553	125	38	3	1	-	-
Hawaii	83	56	1	1	303	290	58	41	9	5	1	8
Guam	1	2	-	-	133	85	7	1	-	7	-	-
P.R.	886	43	6	-	460	660	107	176	2	19	-	-
V.I.	8	-	-	-	249	404	1	8	-	-	-	-
Amer. Samoa	-	1	-	-	44	22	19	-	-	-	-	10
C.N.M.I.	-	-	-	-	106	63	9	6	-	15	-	3

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending August 4, 1990, and August 5, 1989 (31st Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1990	1990	Cum. 1990	1990	Cum. 1990	Cum. 1989	Cum. 1990	1990	Cum. 1990	1990	Cum. 1990	Cum. 1989	1990	Cum. 1990	Cum. 1989
UNITED STATES	668	543	16,438	44	826	10,235	1,612	88	3,596	117	1,854	1,725	14	683	274
NEW ENGLAND	56	-	232	-	21	303	120	2	36	15	233	234	-	7	6
Maine	1	-	27	-	2	-	10	-	-	-	6	6	-	-	
N.H.	4	-	-	-	8	8	5	1	8	10	22	5	-	1	4
Vt.	5	-	-	-	1	3	10	-	1	-	6	6	-	-	1
Mass.	30	-	17	-	4	41	57	1	11	4	184	195	-	2	1
R.I.	4	-	27	-	3	41	11	-	5	-	2	11	-	1	
Conn.	12	-	161	-	3	210	27	-	11	1	13	11	-	3	1
MID. ATLANTIC	147	6	912	-	149	869	240	12	232	8	331	94	1	5	28
Upstate N.Y.	29	5	199	-	109	137	87	9	102	5	259	42	1	4	11
N.Y. City	51	-	201	-	21	79	33	-	-	-	-	3	-	-	15
N.J.	50	-	150	-	10	417	56	-	54	-	13	23	-	-	2
Pa.	17	1	362	-	9	236	64	3	76	3	59	26	-	1	
E.N. CENTRAL	31	-	3,056	-	143	3,084	211	2	363	35	392	245	-	30	24
Ohio	5	-	452	-	3	661	68	-	75	32	118	33	-	1	5
Ind.	2	-	316	-	1	51	22	-	13	-	74	17	-	-	
Ill.	12	-	1,202	-	10	1,946	53	-	114	-	90	88	-	17	19
Mich.	9	-	343	-	125	237	47	2	123	3	44	26	-	9	1
Wis.	3	-	743	-	4	189	21	-	38	-	66	81	-	3	1
W.N. CENTRAL	10	-	750	-	13	623	56	10	103	12	83	104	8	14	6
Minn.	1	-	314	-	3	15	11	7	7	11	17	28	8	9	
Iowa	2	-	23	-	1	6	1	1	16	-	8	12	-	4	1
Mo.	6	-	78	-	-	356	21	-	46	1	48	64	-	-	4
N. Dak.	-	-	-	-	-	-	1	-	-	-	1	-	-	1	
S. Dak.	-	-	15	-	8	-	2	-	3	-	2	4	-	-	
Nebr.	-	-	97	-	1	113	5	-	-	-	2	4	-	-	
Kans.	1	-	223	-	-	133	15	2	31	-	6	3	-	-	1
S. ATLANTIC	140	2	807	43	172	489	294	35	1,489	12	157	134	-	15	6
Del.	2	-	8	-	3	38	2	-	3	-	3	1	-	-	
Md.	38	2	188	-	18	54	35	7	862	1	39	13	-	2	2
D.C.	10	-	15	-	7	25	11	1	29	-	14	-	-	1	
Va.	35	-	68	-	2	21	36	-	85	-	14	9	-	1	
W. Va.	2	-	6	-	-	51	12	-	40	2	12	18	-	-	
N.C.	10	-	9	-	15	168	42	7	220	2	39	27	-	-	1
S.C.	-	-	4	-	-	2	21	3	27	-	5	-	-	-	
Ga.	12	-	80	43§	69	2	54	15	71	7	21	16	-	-	
Fla.	31	-	429	-	58	128	81	2	152	-	10	50	-	11	6
E.S. CENTRAL	15	9	145	-	2	197	93	-	76	2	103	83	-	2	2
Ky.	2	-	29	-	-	20	30	-	-	-	-	1	-	-	
Tenn.	8	9	71	-	-	132	34	-	41	1	43	33	-	1	2
Ala.	5	-	19	-	2	45	27	-	11	1	55	40	-	1	
Miss.	-	-	26	-	-	-	2	-	24	-	5	9	-	-	
W.S. CENTRAL	29	87	3,889	-	86	3,004	110	8	571	2	47	124	-	4	36
Ark.	1	-	12	-	28	3	16	-	128	-	2	16	-	3	
La.	1	-	10	-	-	9	26	2	94	2	16	6	-	-	5
Okla.	8	2	174	-	-	105	15	-	103	-	29	21	-	1	1
Tex.	19	85	3,693	-	58	2,887	53	6	246	-	-	81	-	-	30
MOUNTAIN	16	15	723	-	89	340	50	11	288	3	172	444	-	101	35
Mont.	1	-	-	-	1	13	10	-	1	-	26	26	-	13	1
Idaho	3	-	15	-	10	2	5	-	141	-	35	61	-	49	32
Wyo.	-	-	-	-	11	-	-	-	2	-	-	-	-	-	1
Colo.	2	-	90	-	42	64	15	2	21	1	58	34	-	4	
N. Mex.	1	-	80	-	10	31	6	N	N	2	11	9	-	-	
Ariz.	8	7	267	-	12	119	4	9	100	-	28	300	-	30	
Utah	-	-	71	-	-	109	5	-	8	-	10	13	-	1	
Nev.	1	8	200	-	3	2	5	-	15	-	4	1	-	4	1
PACIFIC	224	424	5,924	1	151	1,326	438	8	438	28	336	263	5	505	129
Wash.	17	-	202	-	69	43	54	-	39	9	81	107	-	-	
Oreg.	12	-	162	-	44	16	47	N	N	2	29	7	-	9	2
Calif.	190	424	5,474	1†	31	1,241	325	8	384	15	194	144	5	486	109
Alaska	2	-	78	-	1	1	8	-	3	-	4	-	-	-	
Hawaii	3	-	8	-	4	28	4	-	12	2	28	5	-	10	21
Guam	2	U	-	U	1	2	-	U	2	U	-	1	U	-	
P.R.	2	-	808	-	-	459	9	-	7	-	5	4	-	-	6
V.I.	-	U	21	U	3	4	-	U	7	U	-	-	U	-	
Amer. Samoa	35	U	132	U	-	-	-	U	15	U	-	-	U	-	
C.N.M.I.	-	U	-	U	-	-	-	U	7	U	-	-	U	-	

*For measles only, imported cases includes both out-of-state and international importations.
N: Not notifiable U: Unavailable †International §Out-of-state

TABLE II. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending August 4, 1990, and August 5, 1989 (31st Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1990	Cum. 1989	Cum. 1990	Cum. 1990	Cum. 1989	Cum. 1990	Cum. 1990	Cum. 1990	Cum. 1990
UNITED STATES	28,356	25,511	199	12,688	12,308	63	232	300	2,466
NEW ENGLAND	1,067	993	15	380	334	2	17	11	4
Maine	5	5	4	-	12	-	-	-	-
N.H.	40	9	1	3	16	-	-	-	2
Vt.	1	-	-	7	5	-	-	-	-
Mass.	416	303	8	166	172	2	16	10	-
R.I.	9	17	1	119	37	-	-	-	-
Conn.	596	659	1	85	92	-	1	1	2
MID. ATLANTIC	5,977	5,247	20	3,253	2,340	1	60	13	560
Upstate N.Y.	520	563	6	257	190	-	13	7	64
N.Y. City	2,686	2,274	5	2,028	1,315	-	32	-	-
N.J.	987	817	-	546	410	1	13	4	176
Pa.	1,784	1,593	9	422	425	-	2	2	320
E.N. CENTRAL	1,922	1,070	47	1,308	1,298	1	21	28	97
Ohio	326	81	17	219	237	1	4	23	5
Ind.	46	40	1	105	121	-	1	-	4
Ill.	733	482	7	646	592	-	11	-	19
Mich.	818	377	22	282	270	-	4	5	26
Wis.	300	90	-	56	78	-	1	-	43
W.N. CENTRAL	262	192	20	336	300	23	1	35	419
Minn.	52	26	1	61	62	-	-	-	159
Iowa	39	21	4	35	28	-	-	-	17
Mo.	145	97	8	166	129	17	1	24	17
N. Dak.	1	3	-	12	11	-	-	-	52
S. Dak.	1	-	-	9	16	3	-	2	139
Nebr.	8	17	3	14	14	1	-	-	4
Kans.	16	28	4	39	40	2	-	9	31
S. ATLANTIC	9,180	9,345	20	2,472	2,574	3	27	114	690
Del.	107	98	1	23	25	-	-	1	13
Md.	700	449	1	194	205	-	8	7	256
D.C.	621	560	1	90	111	-	-	-	-
Va.	488	328	2	215	211	1	2	8	122
W. Va.	33	10	-	41	44	-	-	-	24
N.C.	1,068	580	10	323	306	1	2	62	4
S.C.	575	488	2	285	302	1	-	30	84
Ga.	2,324	2,373	1	389	393	-	1	6	136
Fla.	3,264	4,459	2	912	977	-	14	-	51
E.S. CENTRAL	2,562	1,640	10	976	1,005	5	1	42	114
Ky.	46	36	2	234	244	1	1	5	31
Tenn.	1,071	724	5	277	281	4	-	32	27
Ala.	767	501	3	307	285	-	-	5	56
Miss.	678	379	-	158	195	-	-	-	-
W.S. CENTRAL	4,322	3,388	8	1,589	1,477	20	8	48	279
Ark.	284	208	-	208	153	13	-	9	28
La.	1,150	777	1	150	196	-	-	1	-
Okla.	135	57	7	116	126	7	2	35	84
Tex.	2,753	2,346	-	1,115	1,002	-	6	3	167
MOUNTAIN	547	466	24	300	288	7	18	6	120
Mont.	-	1	-	10	11	-	-	4	34
Idaho	6	1	2	9	14	-	-	-	1
Wyo.	-	3	2	3	-	2	-	-	36
Colo.	25	53	7	14	20	2	-	-	5
N. Mex.	29	20	3	65	53	3	-	1	6
Ariz.	397	144	7	142	138	-	16	1	25
Utah	6	12	3	18	24	-	-	-	5
Nev.	84	232	-	39	28	-	2	-	8
PACIFIC	2,517	3,170	35	2,074	2,692	1	79	3	183
Wash.	218	262	4	162	146	1	2	-	-
Oreg.	91	149	-	76	92	-	4	1	1
Calif.	2,190	2,749	30	1,715	2,312	-	69	2	160
Alaska	10	2	-	26	42	-	-	-	22
Hawaii	8	8	1	95	100	-	4	-	-
Guam	2	4	-	22	54	-	-	-	-
P.R.	204	330	-	66	189	-	-	-	30
V.I.	3	6	-	4	4	-	-	-	-
Amer. Samoa	-	-	-	8	2	-	1	-	-
C.N.M.I.	1	7	-	29	15	-	4	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending August 4, 1990 (31st Week)

Reporting Area	All Causes, By Age (Years)						P&I**
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	546	369	105	44	16	12	53
Boston, Mass.	150	90	37	12	4	7	16
Bridgeport, Conn.	33	25	4	4	-	-	3
Cambridge, Mass.	24	20	4	-	-	-	-
Fall River, Mass.	23	21	-	1	1	-	1
Hartford, Conn.	55	39	6	6	3	1	8
Lowell, Mass.	26	17	9	-	-	-	2
Lynn, Mass.	17	14	1	1	1	-	-
New Bedford, Mass.	21	14	4	3	-	-	2
New Haven, Conn.	41	28	6	3	4	-	7
Providence, R.I.	36	21	8	3	2	2	3
Somerville, Mass.	7	6	1	-	-	-	-
Springfield, Mass.	32	22	5	4	-	1	4
Waterbury, Conn.	31	18	9	4	-	-	2
Worcester, Mass.	50	34	11	3	1	1	5
MID. ATLANTIC	2,644	1,640	517	318	97	72	121
Albany, N.Y.	40	28	5	2	3	2	2
Allentown, Pa.	17	15	2	-	-	-	-
Buffalo, N.Y.	94	61	25	4	2	2	2
Camden, N.J.	38	23	8	4	1	2	-
Elizabeth, N.J.	24	12	5	2	-	5	2
Erie, Pa.†	30	21	5	4	-	-	1
Jersey City, N.J.	47	29	4	8	3	3	2
N.Y. City, N.Y.	1,310	785	344	199	57	25	51
Newark, N.J.	56	26	8	16	6	-	5
Paterson, N.J.§	28	17	5	5	-	1	1
Philadelphia, Pa.	512	322	109	43	21	17	26
Pittsburgh, Pa.†	70	42	18	6	-	4	2
Reading, Pa.	34	25	3	2	1	3	3
Rochester, N.Y.	117	79	23	9	2	4	8
Schenectady, N.Y.	19	12	5	2	-	-	-
Scranton, Pa.†	32	24	7	1	-	-	4
Syracuse, N.Y.	98	66	23	5	1	3	8
Trenton, N.J.	36	21	10	4	-	1	1
Utica, N.Y.	23	20	1	2	-	-	1
Yonkers, N.Y.	19	12	7	-	-	-	2
E.N. CENTRAL	2,175	1,388	471	185	65	66	93
Akron, Ohio	65	45	11	5	4	-	6
Canton, Ohio	30	20	7	1	1	1	4
Chicago, Ill.§	564	362	125	45	10	22	16
Cincinnati, Ohio	147	102	25	10	5	5	13
Cleveland, Ohio	141	80	39	10	8	4	7
Columbus, Ohio	91	58	14	11	2	6	3
Dayton, Ohio	102	68	23	5	4	2	2
Detroit, Mich.	212	128	43	26	10	5	2
Evansville, Ind.	52	34	13	5	-	-	2
Fort Wayne, Ind.	58	20	20	14	2	2	1
Gary, Ind.	11	5	5	1	-	-	-
Grand Rapids, Mich.	61	35	13	6	2	5	6
Indianapolis, Ind.	152	92	37	11	7	5	1
Madison, Wis.§	35	23	8	4	-	-	3
Milwaukee, Wis.	129	90	27	9	-	3	3
Peoria, Ill.	47	24	14	5	1	3	4
Rockford, Ill.	44	30	11	1	1	1	5
South Bend, Ind.	45	40	3	1	1	-	4
Toledo, Ohio	129	85	24	11	7	2	9
Youngstown, Ohio	60	47	9	4	-	-	2
W.N. CENTRAL	680	485	125	42	15	13	46
Des Moines, Iowa	53	42	5	5	-	1	6
Duluth, Minn.	27	18	7	1	1	-	-
Kansas City, Kans.	33	25	8	-	-	-	2
Kansas City, Mo.	89	65	18	3	3	-	3
Lincoln, Nebr.	38	30	6	1	-	1	7
Minneapolis, Minn.	102	74	20	3	3	2	9
Omaha, Nebr.	90	61	15	10	2	2	5
St. Louis, Mo.	142	97	29	7	4	5	9
St. Paul, Minn.	62	43	13	4	1	1	3
Wichita, Kans.	44	30	4	8	1	1	2
S. ATLANTIC	1,369	774	321	170	59	43	55
Atlanta, Ga.	147	78	37	21	6	5	2
Baltimore, Md.	219	136	44	31	5	3	10
Charlotte, N.C.	74	35	27	8	4	-	4
Jacksonville, Fla.	98	52	24	8	10	4	9
Miami, Fla.	121	70	29	17	4	1	1
Norfolk, Va.	53	33	16	1	1	2	4
Richmond, Va.	101	70	15	11	3	2	4
Savannah, Ga.	63	34	14	10	2	3	-
St. Petersburg, Fla.	67	53	10	2	-	2	12
Tampa, Fla.	87	45	24	10	3	3	3
Washington, D.C.	314	151	75	49	21	18	6
Wilmington, Del.	25	17	6	2	-	-	-
E.S. CENTRAL	821	548	163	65	23	22	40
Birmingham, Ala.	108	65	31	3	3	6	1
Chattanooga, Tenn.	66	44	10	8	2	2	3
Knoxville, Tenn.	108	77	23	6	1	1	4
Louisville, Ky.	128	86	26	6	3	7	8
Memphis, Tenn.	167	109	33	16	7	2	14
Mobile, Ala.	72	49	12	8	2	1	-
Montgomery, Ala.	34	27	5	2	-	-	-
Nashville, Tenn.	138	91	23	16	5	3	10
W.S. CENTRAL	1,740	1,088	355	190	62	44	64
Austin, Tex.	44	26	6	7	3	2	5
Baton Rouge, La.	51	36	10	3	1	1	3
Corpus Christi, Tex.	37	24	8	4	1	-	1
Dallas, Tex.	168	96	32	24	11	5	3
El Paso, Tex.	71	42	21	6	1	1	1
Fort Worth, Tex	88	61	16	6	1	4	5
Houston, Tex.§	734	436	169	89	24	16	18
Little Rock, Ark.	72	53	12	2	5	-	3
New Orleans, La.§	125	74	26	14	5	6	-
San Antonio, Tex.	183	124	27	22	5	4	13
Shreveport, La.	83	55	19	5	1	3	9
Tulsa, Okla.	84	61	9	8	4	2	3
MOUNTAIN	733	464	151	86	29	33	25
Albuquerque, N. Mex.	86	56	17	5	6	2	4
Colo. Springs, Colo.	39	26	6	5	2	-	4
Denver, Colo.	140	77	37	11	4	11	2
Las Vegas, Nev.	105	63	28	8	4	2	10
Ogden, Utah	18	12	-	4	1	1	1
Phoenix, Ariz.	156	102	28	12	4	10	1
Pueblo, Colo.	28	20	4	1	2	1	1
Salt Lake City, Utah	43	28	8	1	3	3	-
Tucson, Ariz.	118	80	23	9	3	3	2
PACIFIC	1,891	1,193	345	228	83	37	121
Berkeley, Calif.	16	14	-	2	-	-	1
Fresno, Calif.	58	41	9	4	1	3	5
Glendale, Calif.	30	22	6	2	-	-	-
Honolulu, Hawaii	75	50	14	8	3	-	7
Long Beach, Calif.	77	38	15	14	6	4	11
Los Angeles Calif.	605	369	112	78	36	6	27
Oakland, Calif.	59	37	12	5	2	3	5
Pasadena, Calif.	23	18	1	2	1	1	3
Portland, Oreg.	132	91	22	13	6	-	10
Sacramento, Calif.	147	88	27	22	7	3	18
San Diego, Calif.	135	80	23	19	6	6	12
San Francisco, Calif.	153	85	34	26	3	5	2
San Jose, Calif.	159	107	33	14	4	1	10
Seattle, Wash.	116	75	21	12	5	3	1
Spokane, Wash.	43	35	5	3	-	-	2
Tacoma, Wash.	63	43	11	4	3	2	7
TOTAL	12,599††	7,949	2,553	1,298	449	342	618

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 o more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are no included.

**Pneumonia and influenza.

†Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

††Total includes unknown ages.

§Data not available. Figures are estimates based on average of past available 4 weeks.

IVDUs — Continued

TABLE 1. Reported intravenous (IV)-drug use behaviors at initial and first 6-month follow-up interviews — selected cities, United States, 1987–1989

Category	Miami	Chicago	Philadelphia	Houston	San Francisco
Description of study population					
No.	376	561	100	415	132
Male	76%	72%	74%	79%	73%
Age <40 years	77%	53%	78%	80%	52%
Black	80%	55%	57%	56%	58%
Entered drug treatment	14%	25%	32%	22%	35%
Reported frequency of IV-drug use at follow-up					
No.	370	557	100	415	132
Stopped*	47%	16%	26%	32%	17%
Decreased without stopping	28%	40%	36%	28%	32%
No change	15%	23%	21%	15%	33%
Increased	11%	22%	17%	24%	19%
Reported not sharing drug-injection equipment with friends					
At initial interview	198/371 (53%)	101/559 (18%)	29/97 (30%)	203/430 (47%)	52/132 (39%)
At follow-up†	176/239 (74%)	242/519 (47%)	48/77 (62%)	294/336 (88%)	75/110 (68%)
Reported not borrowing previously used drug-injection equipment					
At initial interview	187/370 (51%)	226/556 (41%)	38/97 (39%)	205/426 (48%)	64/132 (48%)
At follow-up§	169/240 (70%)	316/511 (62%)	51/77 (66%)	217/335 (65%)	68/110 (62%)
Reported using bleach for cleaning drug-injection equipment					
No.¶	240	519	77	335	110
Always used bleach					
At initial interview	3%	10%	6%	4%	36%
At follow-up	11%	23%	16%	19%	43%
Bleach use at follow-up					
Increased	20%	39%	28%	32%	26%
No change	71%	48%	69%	64%	53%
Decreased	9%	13%	3%	4%	21%

*Stopped for at least 1 month immediately before follow-up interview.
†Persons reporting not sharing drug-injection equipment during the 6 months before the follow-up interview among those still using IV drugs at follow-up.
§Persons reporting not borrowing drug-injection equipment during the 6 months before the follow-up interview among those still using IV drugs at follow-up.
¶Of persons continuing to use IV drugs, except for those who reported always using new needles.

IVDUs – Continued

In all five cities, the percentage of IVDUs who reported not sharing drug-injection equipment with friends increased in the approximately 6 months between initial and follow-up interviews, as did the percentage of IVDUs who reported not borrowing previously used drug-injection equipment (Table 1). Thirty-four percent (Houston) to 59% (Chicago) of IVDUs reported decreased sharing of drug-injection equipment; 22% (San Francisco) to 37% (Chicago) of IVDUs reported decreased borrowing of drug-injection equipment.

Of those who continued to inject drugs at follow-up, except for those who reported always using new needles, 20%–39% of IVDUs reported increased use of bleach for cleaning drug-injection equipment (Table 1). Eleven percent to 43% of IVDUs reported consistent use of bleach.

Regular condom use with a steady sex partner increased in three cities to 12%–16% (Table 2). Regular condom use with multiple sex partners increased in four cities to 10%–27%.

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TABLE 2. Reported use of condoms by intravenous-drug users at initial and first 6-month follow-up interviews – selected cities, United States, 1987–1989

Category	Miami	Chicago	Philadelphia	Houston	San Francisco
Reported condom use with a steady partner					
No.	43	53	29	58	25
Reported always using condoms					
At initial interview	2%	32%	17%	3%	4%
At follow-up	16%	23%	3%	12%	12%
Change in reported use of condoms					
Increased use	21%	17%	3%	22%	16%
No change	77%	61%	69%	71%	80%
Decreased use	1%	23%	28%	7%	4%
Reported condom use with multiple partners					
No.	187	91	22	203	25
Reported always using condoms					
At initial interview	10%	29%	5%	3%	16%
At follow-up	27%	14%	23%	10%	24%
Change in reported use of condoms					
Increased use	44%	31%	37%	48%	28%
No change	42%	24%	50%	37%	48%
Decreased use	13%	45%	14%	14%	24%

IVDUs — Continued

Drug Abuse, Alcohol, Drug Abuse, and Mental Health Administration. Office of the Director, Center for Prevention Svcs, CDC.

Editorial Note: IV-drug use is an important factor in the transmission of HIV (*2*). Of the 117,781 persons with acquired immunodeficiency syndrome (AIDS) reported in the United States in 1989, 36,356 (30.8%) are in a risk-behavior category directly or indirectly related to IV-drug use (*3*).

IVDUs are difficult to reach and influence with traditional public health education and other prevention interventions (*4*). Although drug-treatment centers can serve the dual purpose of drug treatment and HIV prevention, an estimated 80% of active IVDUs are not in treatment (National Association of State Alcohol and Drug Abuse Directors, unpublished data). New approaches and more effective strategies for reaching IVDUs not in drug treatment are needed to decrease drug use and stem the HIV epidemic.

These preliminary results, which show an overall reduction in high-risk behaviors of IVDUs, suggest that participation in outreach and intervention programs can influence entry into drug-treatment programs and reduce drug-injection behaviors associated with increased risk for HIV transmission. The lowest rates for IVDUs entering drug-treatment programs were in Miami and Houston, where capacities of publicly funded drug-treatment programs are limited. Stronger evidence of the considerable impact that this approach could have if implemented nationwide would be provided if the results at other sites prove to be consistent with these preliminary results.

A related study in San Francisco (*5*) suggests that outreach programs affect even the behaviors of IVDUs in the community who did not participate directly in the interventions. Cross-sectional samples of approximately 500 IVDUs recruited at 6-month intervals during 1986 and 1989 revealed that the introduction of outreach programs to IVDUs in 1986 corresponded with the start of communitywide increases in bleach use (from 3% in 1986 to 86% in 1989).

The Health Behavior Projects in Newark and Jersey City, New Jersey, have shown that IVDUs can be recruited directly from the street and community to enter drug-treatment programs when drug treatment is made more accessible. In these projects, 49% of 1884 IVDUs who participated in intake interviews subsequently entered 21- or 90-day methadone treatment programs at no charge (M.Y. Iguchi, unpublished data, 1990).

The results reported here reflect the effectiveness of street outreach combined with additional behavior-change interventions such as HIV counseling and testing. An additional strength of the projects may be the use of nontraditional outreach workers to recruit IVDUs into treatment. As in other studies (*4*), reported reductions in drug-use risk behaviors were larger than reductions in sexual risk behaviors.

Recruiting drug users into and keeping them in well-managed, effective drug-treatment programs can reduce risk behaviors for HIV infection (*6*). This strategy is essential to all HIV-prevention programs for drug users. Additional strategies are needed to reach drug users not in treatment programs. Since peers may influence former drug users to use drugs, drug-treatment and HIV-prevention programs need to provide long-term, repeated contacts with IVDUs who have returned to the community after drug treatment.

Street/community outreach is an important element of a comprehensive program to reach IVDUs in a variety of settings (including drug-treatment centers, public health

IVDUs – Continued

clinics, free-standing HIV counseling and testing programs, correctional facilities, and health-care facilities such as hospitals and emergency rooms) and is best coordinated at the community level to assure maximum coverage and effectiveness (*7*). Project TRUST in Boston (*8*) and South Carolina's survey of clients in alcohol- and drug-treatment centers (*9*) are efforts to meet the specific needs of IVDUs for HIV prevention. Continuous reassessment is important in determining how outreach can be most effectively used in HIV and drug-treatment programs.

References

1. CDC. Risk behaviors for HIV transmission among intravenous-drug users not in drug treatment—United States, 1987–1989. MMWR 1990;39:273–6.
2. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, January 1990:9.
3. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, July 1990:8.
4. Turner CF, Miller HG, Moses LE, eds. AIDS sexual behavior and intravenous drug use. Washington, DC: National Academy Press, 1989.
5. Watters JK, Cheng Y, Segal M, Lorvick J, Case P, Carlson J. Epidemiology and prevention of HIV in intravenous drug users in San Francisco, 1986–1989 [Abstract]. Vol 2. VI International Conference on AIDS. San Francisco, June 20–24, 1990:116.
6. Hartel D, Selwyn PA, Schoenbaum EE, Klein RS, Friedland GH. Methadone maintenance treatment (MMTP) and reduced risk of AIDS and AIDS-specific mortality in intravenous drug users (IVDUs) [Abstract]. Book 2. IV International Conference on AIDS. Stockholm, June 12–16, 1988:395.
7. CDC. Coordinated community programs for HIV prevention among intravenous-drug users—California, Massachusetts. MMWR 1989;38:369–74.
8. CDC. Counseling and testing intravenous-drug users for HIV infection—Boston. MMWR 1989;38:489–90,495–6.
9. CDC. Characteristics of clients in alcohol- and drug-treatment centers—South Carolina, 1989. MMWR 1990;39:519–20.

Notice to Readers

Deadline for Filing Claims for Compensation Under the National Childhood Vaccine Injury Act

Public Law 99-660 established the National Vaccine Compensation Program to compensate persons injured by certain childhood vaccines. Persons injured by childhood vaccine before October 1988 have until October 1, 1990, to file claims for compensation through this program. Details on filing a claim are available from the Health Resources and Services Administration at a toll-free number: (800) 338-2382.

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